TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ROSSEL MEDICAL CARE PLLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-1801-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary with the DWC060 request. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $275.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ROSSEL MEDICAL CARE PLLC provided services to the claimant on the date above... One year from disputed date 1/22/16 is 1/22/17. The TDI/DWC date stamp lists the received date as 2/13/17 on the requestor's DWC-60 packet, a date greater than one year from 1/22/16. The requestor has waived its right to DWC MDR for disputed dates 9/25/15, 10/23/15, 11/20/15, 12/18/15, and 1/22/16. The requestor billed Texas Mutual code 99080-73 for dates 2/26/16, 3/24/16, 4/22/16, 6/24/16, 7/29/16, 8/26/16, 9/26/16, and 10/28/16. Texas Mutual declined to issue payment absent any change in work status since 12/18/15. (Attachment) Nor is there any record Texas Mutual requested these on a scheduled bases. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2015 through October 28, 2016	99080-73 x 13	$275.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out the guidelines for Work Status Reports.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5
   - 249 – DWC-73 not submitted; not properly completed and/or missing doctors signature; reimbursement denied per rule 129.5
   - A01 – Rule 129.5 indicates DWC 72 must be billed and filed by the doctor

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service September 25, 2015 through January 22, 2016?
2. Did the requestor complete the DWC-73 in the form and manner prescribed by the Commission?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99080-73 rendered on September 25, 2015 through January 22, 2016. 28 Texas Administrative Code §133.307(c) (1) states, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The dates of the service in dispute are September 25, 2015 through January 22, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on February 13, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file dates of service September 25, 2015 through January 22, 2016 with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates.
2. The requestor seeks reimbursement for CPT Code 99080-73 rendered on February 26, 2016 through October 28, 2016, denied by the insurance carrier with denial reason code(s):
   - 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5
   - 249 – DWC-73 not submitted; not properly completed and/or missing doctors signature; reimbursement denied per rule 129.5.
   - A01 – Rule 129.5 indicates DWC 72 must be billed and filed by the doctor

   Per 28 Texas Administrative Code §129.5 "(c) The doctor shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the Commission, signed, and contains at minimum: (1) identification of the employee's work status; (2) effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future Work Status Reports, as appropriate, based on the condition and progress of the employee); (3) identification of any applicable activity restrictions; (4) an explanation of how the employee's workers' compensation injury prevents the employee from returning to work (if the doctor believes that the employee is prevented from returning to work); and (5) general information that identifies key information about the claim (as prescribed on the report)."

   Per 28 Texas Administrative Code §129.5 "(d) The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee."

   Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that the requirements of 28 Texas Administrative Code §129.5 (d) were met. As a result, the requestor is not entitled to reimbursement for CPT code 99080-73 rendered on February 26, 2016 through October 28, 2016.
3. For the reasons stated above, the division finds that the requestor is not entitled to reimbursement for CPT code 99080-73 rendered on February 26, 2016 through October 28, 2016.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.